

CLINICAL GUIDELINES FOR SEEKING SECOND OPINION

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SCOPE

Services	Applicable	Comments
Trustwide	✓	

The Director responsible for monitoring and reviewing this Clinical Guideline is the Executive Medical Director

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CLINICAL GUIDELINES FOR SEEKING SECOND OPINION

Assurance Statement

This clinical guideline has been developed to ensure that safe working practices can be adopted when seeking second opinion for treatment and diagnosis.

1.0 INTRODUCTION

- 1.1 Second opinions appear to be increasingly requested and are often an issue in relation to enquiries made to the Trust, e.g. through the PALS and the Complaints Department.
- 1.2 The commonest reasons for second opinions to be requested are in cases of uncertainty or disagreement over diagnosis, dissatisfaction with the outcome of treatment and/or when a patient has good reason for wanting a different clinician to be involved with their case.
- 1.3 Whilst, therefore, patients do not have an automatic right to a second medical opinion, there are certain ethical obligations placed upon doctors when considering the specialist care needs of their patients.
- 1.4 This clinical guideline has been discussed, commented upon and agreed by the Trust's Consultant Body.

Definition

- 1.5 A second opinion is an independent expert assessment of a clinical problem. Where requested by the treating clinician, the assessment is usually requested either to review/uphold a potentially controversial decision or to offer fresh options in a case where response to treatment has been incomplete. [Nirodi P, Mitchell AJ, Mindham RHS (2003)]
- 1.6 Where a patient, relative or carer requests a further opinion, this may be because that person does not agree with or has some doubts about the consultant's diagnosis and/or proposed course of treatment and would wish an opinion like confirmation by another consultant or the possibility of alternative diagnoses or treatment to be explored.
- 1.7 Unless specified the term second opinion clinician refers to clinicians employed by EPUT

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Mental Health Act 1983 (amended 2007)

- 1.8 The MHA sets out circumstances where a second opinion is a statutory (legal) requirement with specific reference to second opinions in relation to treatment of detained patients. Part 1V of the Act relates to consent to treatment and Sections 57 and 58 are the most relevant to the question of second opinions. Treatments under S58 (ECT or medication after 3 months) require consent or a second opinion from 'a registered medical practitioner appointed for the purposes of this Part of the Act by the Secretary of State'. The less commonly used S57 requires consent and a second opinion specific reference to second opinions in relation to treatment of detained patients. Part IV of the Act relates to consent to treatment.
- 1.9 The Code of Practice covers consent to treatment for detained patients and statutory second opinions, with paragraphs dealing specifically with the procedure for second opinions and the role of the Second Opinion Appointed Doctor (SOAD). An extract from the Code of Practice is attached to this clinical guideline as an appendix.
- 1.10 The rest of this guidance refers to requests for second opinions outside the terms of the MHA, including non-statutory requests for second opinions on detained patients.

2.0 SCOPE

- 2.1 The main emphasis is on medical second opinions, though similar principles may apply for other professional groups.
- 2.2 This clinical guideline does not cover transfer of care arrangements, which are set out in other medical directorate protocols.
- 2.3 Models of working may involve consultants working predominantly in the community and others predominantly in inpatient settings. Where such models involve multidisciplinary team meetings which involve community and inpatient consultants for a sector, consultants would be regarded as having involvement in the care provided to patients discussed in that forum but that involvement does not constitute a second opinion in terms of this clinical guideline.

3.0 REQUESTS FOR SECOND OPINIONS

- 3.1 A reasonable request from a patient for a second opinion should not be refused.
- 3.2 What is reasonable should be considered on an individual basis with consideration of the circumstances of the individual case. This will require the exercise of clinical judgement in a spirit of openness and respect for patient choice.

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- 3.3 Where possible Requests for a second opinion should be made in writing to the responsible consultant. However requests for second opinions may be made directly to the treating Consultant verbally during an appointment or review.
- 3.4 All written requests must be acknowledged within ten (10) days of receiving the request. The second opinion must be provided within a reasonable time of typically 4 to 6 weeks unless the opinion is urgent.
- 3.5 Requests made directly to the treating Consultant verbally during an appointment or review should be acknowledged separately or reflected in the output letter from such appointment or review, a copy of which should be sent to the patient.
- 3.6 Requests for second opinion are likely to come from four sources:
- From patients themselves,
 - From the treating clinician
 - From third parties (usually relatives or carers)
 - From the patient's General Practitioner, which will sometimes be at the request of the patient, relative or carer.

3.6.1 – Requests from Patients

If the patient has requested the second opinion, then their consent can be generally implied, though it will still be wise to record the prior discussion in the case notes.

3.6.2 – Requests from a Clinician

Where the clinician instigates the request, there needs to be discussion with the patient and an understanding (where possible) of what is involved and why the opinion is being sought.

3.6.3 – Requests from Relatives or Carers

Third party requests can be more contentious and the consent of the patient to the referral is necessary. The exception to this is where a patient lacks mental capacity around their treatment and a relative /carer is acting in their best interest. In determining whether a patient lacks capacity the legal requirements as set out in the Mental Capacity Act 2005 should be adhered to and the process for determining best interest should also be followed.

Other exceptions include where the carer has parental responsibility over a patient below the age of 18 or where a power of attorney arrangement is active covering health and welfare.

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3.6.4 – Requests from patient's General Practitioner

Where requests originate from the GP, this would usually be as a result of concerns raised by the patient directly with the GP. In a minority of cases, the GP may request a second opinion if they disagree with proposed management plans. In these cases, a discussion should take place with the GP to clarify issues which are in dispute and a further discussion should occur with the patient highlighting what has been agreed following the GP request.

The responsible clinician would generally be involved in making the request for another opinion, even if he/she is not the initiator of the request. The responsible clinician should advise the patient that the request is for an opinion only.

- 3.7 The essence of the second opinion is that it is an independent opinion, based ideally on a face to face clinical assessment and relevant other information such as records, by the clinician providing the opinion. In most cases, an immediate colleague would be appropriate, as they would generally be more accessible. However, depending on the circumstances, it may be appropriate to ask a colleague in the same speciality based at a different location or else a Consultant from a different speciality if they have the necessary expertise. This must remain an area for individual judgement.

4.0 REQUESTS FOR OPINIONS OUTSIDE THE TRUST

Requests for an opinion outside the Trust may occasionally be made. For example, this may be requested where a patient or relative/carer want an opinion by or referral to a specialist unit outside the Trust (e.g. the Maudsley). In some cases this request may be clinically appropriate although funding would need to be agreed through the usual process.

Where the treating clinician does not agree it is appropriate, the treating clinician should offer a second opinion from another Consultant within the Trust. Situations may also occur where the patient or third party asks for an opinion outside the Trust because they believe another doctor from the Trust would not provide an independent opinion or if they have a grievance with the Trust as a whole or they may feel that all doctors in the Trust are in allegiance and not therefore truly independent. Under these circumstances, if the Trust has made reasonable attempts to provide an independent opinion from within the Trust and this has been unreasonably declined, then the Trust would not be obliged to seek an independent expert opinion outside the Trust. The treating clinician in this case should seek advice from their Clinical Director, for consideration of whether referral may be made for a one-off opinion to a Consultant outside the Trust. This referral would be for opinion only and would need to be authorised by the Executive Medical Director.

5.0 DEALING WITH DISAGREEMENTS AND DISPUTES ON SECOND OPINIONS

- 5.1 In some cases, a second opinion has been provided, but the patient or third party remain unsatisfied and request a further review. It is advisable that the treating clinician and the clinician who provided the second opinion should discuss this further and the treating clinician should discuss with the Clinical Director. Such a request may be reasonable but the clinician is in a stronger position to decline.
- 5.2 In most cases, the advice given by the second opinion is likely to be helpful to both the patient and the original clinician. However, where the second opinion has been requested by the patient or a third party this may not be the case. If the clinician providing the second opinion, when completing their assessment considers their advice will seriously conflict with the opinion and treatment of the original clinician, he/she must consider the implications of this and not deliberately act in a manner likely to jeopardise/adversely affect the professional relationship between the patient and the original clinician e.g. being unduly critical of the current treatment plan in communications with the patient/ original clinician either verbally or written. If the patient wishes to follow the recommendations of the clinician giving the second opinion and the original consultant disagrees with the second opinion, the relevant Clinical directors may assist in mediation and/or another opinion may be sought internally prior to consideration of seeking an independent expert opinion from outside the Trust with the agreement of the Executive Medical Director.

If the request for a second opinion is of a more specialist nature or the patient feels that referral to an alternative psychiatrist within the Trust is unacceptable, a referral may be made for a one-off opinion to a Consultant outside the Trust with the prior approval of the Executive Medical director. This referral would be for opinion only and would not commit the second opinion doctor to taking the patient on for treatment. The opinion of the second opinion doctor should be readily available to the patient. If the second opinion is substantially different and the differences cannot be resolved, referral should be made to the Executive Medical Director.

- 5.3 In cases of dispute or conflict, a request for advice should be made to the relevant Clinical director/ associate medical directors on behalf of the Executive Medical director who may review the cases notes and discuss the case with the treating consultant, if necessary the team looking after the patient and the patient his/herself following which decision will be made about the appropriate course of action.

Where the original consultant disagrees with the second opinion, an independent expert opinion from outside the trust can be sought. The Executive Medical Director should be made aware and agree this course of action.

In all instances, the "Executive Medical Directorate protocols" for second opinion must be followed.

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6.0 REFUSING A REQUEST FOR A SECOND OPINION

- 6.1 In some circumstances it may be felt that it is in the patient's best interest to refuse a request for second opinion. e.g. a patient who is detained in hospital who does not accept they are ill and where the MDT agree a second opinion would not be therapeutic and would re-enforce a patients difficulty in engaging with treatment/the clinical team. In such an instance the use of the MHA appeals processes may be more appropriate than a second opinion.
- 6.2 The decision to refuse a request for a second opinion should be taken rarely and only after some careful consideration. In these circumstances the reason that the request has been declined should be given in writing to the Patient and documented in the clinical notes. The Patient should also be advised to seek support from the advocacy services and be facilitated to do so. If a request is refused, a full explanation should be given. All cases in which a request for second opinion is refused should be referred to the Clinical Director who will look at the case notes, discuss the case with the treating consultant and if necessary the team looking after the patient and the patient him/herself following which decision will be made about the appropriate course of action.

7.0 COMPLAINTS PROCEDURE

- 7.1 It is not appropriate for any staff of the Trust to advise patients to use the complaint procedure to obtain a second opinion or alternative consultant. However, if the patient does not think that their request or concern has been adequately addressed they may wish to take this matter further by using the complaint procedure.

8.0 IMPLEMENTATION

- 8.1 All clinical directorates are responsible for implementing this clinical guideline.
- 8.2 This clinical guideline should be included in the induction programme for all clinical staff.

9.0 MONITORING AND REVIEW

- 9.1 The Executive Medical Director is responsible for monitoring and the review of this clinical guideline.

END